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Social Science & Medicine 84 (2013) 22–29

Contents lists available at SciVerse ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

Managing uncertainty: A grounded theory of stigma in transgender health care encounters

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ARTICLE INFO

Article history:
Available online 19 February 2013

Keywords:
USA
Stigma
Transgender
Health care access
Doctor–patient communication
Grounded theory
Qualitative research
Health disparities

ABSTRACT

A growing body of literature supports stigma and discrimination as fundamental causes of health disparities. Stigma and discrimination experienced by transgender people have been associated with increased risk for depression, suicide, and HIV. Transgender stigma and discrimination experienced in health care influence transgender people's health care access and utilization. Thus, understanding how stigma and discrimination manifest and function in health care encounters is critical to addressing health disparities for transgender people. A qualitative, grounded theory approach was taken to this study of stigma in health care interactions. Between January and July 2011, fifty-five transgender people and twelve medical providers participated in one-time in-depth interviews about stigma, discrimination, and health care interactions between providers and transgender patients. Due to the social and institutional stigma against transgender people, their care is excluded from medical training. Therefore, providers approach medical encounters with transgender patients with ambivalence and uncertainty. Transgender people anticipate that providers will not know how to meet their needs. This uncertainty and ambivalence in the medical encounter upsets the normal balance of power in provider–patient relationships. Interpersonal stigma functions to reinforce the power and authority of the medical provider during these interactions. Functional theories of stigma posit that we hold stigmatizing attitudes because they serve specific psychological functions. However, these theories ignore how hierarchies of power in social relationships serve to maintain and reinforce inequalities. The findings of this study suggest that interpersonal stigma also functions to reinforce medical power and authority in the face of provider uncertainty. Within functional theories of stigma, it is important to acknowledge the role of power and to understand how stigmatizing attitudes function to maintain systems of inequality that contribute to health disparities.

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Introduction

A growing body of literature supports stigma and discrimination as fundamental causes of health disparities (Krieger, 1999, 2012; Link & Phelan, 1995; Meyer & Northridge, 2007). Stigma has been defined as a social process of "othering, blaming, and shaming" that leads to status loss and discrimination (Deacon, 2006, p. 418). Stigma researchers, Link and Phelan further define discrimination as the process by which stigmatized groups are devalued through the exercise of social, cultural, economic, and political power (Link & Phelan, 2006). Structural and institutional discrimination includes both intentional and unintentional policies and practices that result in restricted opportunities for stigmatized people (Corrigan, Markowitz, & Watson, 2004).

Norton and Herek (2012) recently published a study that analyzed data from a national probability sample of heterosexual U.S. adults ($N = 2281$) and described respondents' self-reported attitudes toward transgender people (i.e. those whose gender differs from their sex at birth). Attitudes toward transgender people and other groups were measured with a series of 101-point feeling thermometers in which higher numbers indicated more favorable attitudes with 50 serving as "neutral." The mean score for transgender people was 32.01. No strata of respondents had a mean score greater than 50. These findings of generally negative attitudes toward transgender people are consistent with studies among transgender people in which they report widespread stigma and discrimination (Grant et al., 2011; Norton & Herek, 2012).

Published literature on health care provider attitudes toward transgender people is quite limited. Most studies examine attitudes

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0277-9536/$ – see front matter Published by Elsevier Ltd.
http://dx.doi.org/10.1016/j.socscimed.2013.02.019

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toward lesbian, gay, bisexual, and transgender (LGBT) populations, in general, rather than transgender patients in particular (Dean et al., 2000; Dorsen, 2012; Lurie, 2005; Vanderleest & Galper, 2009). A recent review of literature on nurses' attitudes toward LGBT patients showed evidence of negative attitudes in all 17 articles (Dorsen, 2012). A study of 427 LGBT physicians found that 65% had heard derogatory comments about LGBT individuals and 34% had witnessed discriminatory care of an LGBT patient (Eliason, Dibble, & Robertson, 2011). These studies may underestimate transgender discrimination given that Norton and Herek (2012) found that attitudes toward transgender people are significantly less favorable than toward LGB. A recent study examining the LGBT content of medical curricula in the United States have found little to no education on transgender health (Obedin-Maliver et al., 2011).

The stigma and discrimination faced by transgender people (i.e. those whose gender differs from their sex at birth) have been associated with increased risk for depression, suicide, and HIV (De Santis, 2009; Dworkin & Yi, 2003; Lawrence, Meyer, & Northridge, 2007; Lombardi, Wilchins, Priesing, & Malouf, 2001; Risser et al., 2005). Transgender people also face significant barriers to accessing health care. A national study found double the rate of unemployment among transgender people, compared to the general population. Not surprisingly, transgender people were also less likely than the general population to have health insurance and less likely to be insured by an employer (Grant et al., 2011). Among a sample of 182 transgender people in Philadelphia (Kenagy, 2005), one-third reported having no primary care physician and one quarter had no access to general medical care compared to 10% of the general population (National Center for Health Statistics, 2007).

One in four respondents in the Kenagy (2005) study had been denied medical care just because they were transgender. In a more recent national study of health care experiences of LGBT people and people living with HIV (PLHIV), 70% of 397 transgender respondents reported experiencing some form of health care discrimination, compared to 56 percent of LGB respondents and 63 percent of PLHIV (Lambda Legal, 2010). Over a quarter of all transgender respondents (26.7%) reported being denied care because of their transgender identity, compared with 7.7% of LGB respondents denied care because of their sexual orientation and 19% of PLHIV denied care because of their HIV status.

Even when transgender people are able to access health care, the care they receive is often far from ideal. A statewide needs assessment conducted in Virginia (Xavier, Hannold, Bradford, & Simmons, 2007) found that 46% of transgender respondents had to educate their regular doctors about their health care needs. The National Transgender Discrimination Survey (NTDS) (Grant et al., 2011) of over 6000 transgender and gender non-conforming individuals throughout the U.S. found that 50% of respondents reported having to teach their medical providers about transgender care. Beyond this lack of clinical competence, some transgender people experience outright mistreatment from medical providers. Lambda Legal (2010) found that 20.9% of transgender respondents had been subjected to harsh language, and 20.3% of them reported being blamed for their own health problems. Fifteen percent reported that health care professionals refused to touch them or used excessive precautions, and 7.8% experienced physically rough or abusive treatment by a medical provider. The prevalence of mistreatment among transgender respondents was twice that of lesbian, gay, and bisexual respondents.

Given their experience, many transgender people are wary of the health care system. Ninety percent of transgender people surveyed by Lambda Legal (2010) believed there are not enough medical personnel who are properly trained to care for them, and 52% worried about being refused medical services when they need them. This wariness has significant consequences for the health of transgender people. In the NTDS (Grant et al., 2011), 33% of respondents reported that they postponed preventive medical care due to discrimination, and 28% postponed care even when they were sick or injured.

Mistrust of the health care system also leads some transgender people to seek care outside the formal sector. Xavier et al. (2007) found that half of the hormone-experienced study participants had obtained their hormones from someone other than a doctor, and nearly 46% of them had injected themselves with hormones or received a hormone injection from someone other than a doctor or nurse, including 71% of transmen and 37% of the transwomen. While there is little data on the effect of gender-affirming medical care on the physical health of transgender people, one study from New York City found that transgender people with access to such care had lower rates of risky health behaviors such as cigarette smoking and illicit use of syringes for hormone injection (Sanchez, Sanchez, & Danoff, 2009).

It is clear that transgender people face stigma and discrimination in health care settings; and that this stigma influences their health care access and utilization. Thus, understanding how stigma and discrimination manifest and function in health care encounters is critical to addressing health disparities for transgender people. In order for change to take place, this understanding must take into account both provider and patient perspectives on the health care encounter. To date there has been no published literature exploring how discrimination functions in health care encounters between transgender patients and medical providers. This qualitative study was conducted to address this gap.

Methods

This paper presents a Grounded Theory analysis (Charmaz, 2006) of field notes and in-depth interviews conducted with medical care providers and transgender adults as part of a larger study examining stigma, access to care and HIV risk among transgender people. Consistent with the principles of Grounded Theory, the review of stigma theory literature was deferred until after data analysis. To ground the study in the community, two community advisory boards (CABs) were convened before data collection began. One CAB was made up of transwomen and the other was made up of transmen. Each CAB met approximately monthly before and during data collection and as needed after data collection was complete. CABs provided input into the development of study materials, assisted with recruitment, and offered suggestions for interpreting preliminary findings. The busy schedules of health care providers prevented the formation of a CAB of medical providers.

Data collection

Purposive sampling was used to identify transgender participants and clinicians who provided medical care for transgender people. Sampling for transgender participants was stratified by gender in order to ensure adequate participation by both transmen and transwomen. In addition, efforts were made to achieve variability along lines of race, engagement in medical care, and use of hormone therapy, as these characteristics were theorized to affect both discrimination and health care experiences.

In-depth interviews were conducted with both transgender adults and health care providers in a small industrial city in the mid-Atlantic from January to July 2011. Interviews were audio-recorded and transcribed verbatim. Field notes were handwritten immediately after each interview and typed once transcription was complete. Transgender adults were recruited by placing flyers in the city's LGBT health center as well as through announcements

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during transgender support groups and by outreach to organizations that provide services and advocacy for the transgender community. In addition, CAB members recruited transgender people from their social networks, and transgender study participants were encouraged to refer other transgender people. Health care providers were recruited from medical practices known to provide care for transgender patients, including primary health care as well as hormone therapy and surgical referrals. All participants provided verbal informed consent; and all interviews were audio taped and transcribed verbatim.

Transgender participants

Inclusion criteria for transgender participants included being age 18 years or older, residing in the metropolitan area, and identifying as transgender or as a gender different from their birth sex. Each potential participant was screened over the telephone. Participants meeting the inclusion criteria were scheduled for an interview at the project office located in a central area of the city, accessible by public transportation.

One individual in-depth interview was conducted with each of the 55 transgender participants, including 25 transmen and 30 transwomen. Each interview lasted between 45 and 180 min with an average duration of 90 min. The interviews elicited detailed narratives of individual experiences and perceptions. Specifically, participants were asked about their family and social life, gender identity, sexual orientation and practices, health care experiences, as well as experiences of stigma and discrimination. Transgender participants were reimbursed $25 for their time.

The average age of the transwomen in the study was 39 years (range 21–66). Two-thirds of the transwomen identified as Black or African-American, the remainder identified as white. Half of the transwomen participants had no more than a high school education. Twenty-six of the thirty transwomen had a regular source for medical care. Two-thirds of them had been tested for HIV in the previous year. Of the five transwomen who reported having HIV, all of them had been diagnosed for greater than 10 years.

The average age of the transmen in the study was 33 years (range 21–57). Approximately one-quarter of the transmen identified as Black or African-American. Half of the transmen identified as white and the remainder as mixed or other race. All of the transmen were high school graduates, and all but two of them had at least some college. Twenty of the twenty-five transmen had a regular source for medical care. Eighteen of them had an HIV test in the previous year; none reported having HIV.

Health care providers

Inclusion criteria were being at least age 18 years, working in the metropolitan area, and having provided medical care to at least one transgender patient in the preceding year. Emails inviting participation were sent to medical providers at institutions recommended by the CAB and known by the author to provide care for transgender patients. All providers who expressed interest and who met the inclusion criteria were scheduled for interviews at the project office or their own office depending on their choice. Interviews included questions about their personal history and clinical training as well as about their experiences providing care for transgender patients. Each interview lasted between 45 and 90 min with an average duration of 60 min. No monetary reimbursement was provided to health care providers.

The 12 medical providers included: 7 primary care providers from the local LGBT health center (4 physicians, 2 nurse practitioners, and 1 physician assistant), 2 endocrinologists and 1 physician assistant from a large academic medical center, 1 adolescent medicine specialist from another large academic medical center, and 1 physician in private practice. None of the medical providers self-identified as transgender.

Research team and reflexivity

The first author conducted 39 of the 55 interviews with transgender participants and 11 of the 12 interviews with medical providers. She is an African-American non-transgender woman who conducted this study as part of her doctoral dissertation. For two years prior and during the course of this study, she provided medical care at the local LGBT health center and participated in a local coalition of organizations serving the transgender community. Two of the transgender people she interviewed were her patients and declined to be interviewed by the research assistant, though this was offered. She had collegial relationships with 6 of the providers whom she interviewed for the study. All were offered the opportunity to interview with the research assistant and declined. A trained graduate research assistant with a bachelor's degree in anthropology conducted 16 of the interviews with transgender participants and one of the interviews with medical providers. She is an Asian-American non-transgender woman who had experience working in HIV prevention with transgender communities in a different urban area in the U.S.

As an ally of the transgender community and a medical provider, the first author has an investment in the potential policy and programmatic implications of the findings of this study as well as presuppositions about the nature of stigma and discrimination in health care encounters. Several measures were taken to clarify the researcher's stance in relation to the participants and the subject matter. Both the first author and the research assistant wrote reflexive notes as well as general field notes at the end of each interview. In addition, the research assistant used the health worker interview guide to interview the first author. The transcript from this interview was not analyzed as part of the data set but was used along with a reflexive journal kept by the first author to help distinguish her views from those of the study participants.

Ethics and funding

The Institutional Review Board at Johns Hopkins School of Public Health provided ethical approval for this study. To maximize confidentiality, no individual identifiers were collected, and no written consent forms were used. Prior to enrollment, all recruited individuals were read the contents of the oral consent form and given ample opportunity to ask questions before providing verbal consent for participation. Funding for this study was provided by the Johns Hopkins Center for Health Disparities Solutions and the Johns Hopkins Center for Public Health and Human Rights. None of the funders played any role in the collection, interpretation, or presentation of the data.

Analysis

Data for analysis included transcripts of audio recordings from the in-depth interviews as well as typed field notes from all data collection activities. The first author coded the transcripts in the software program Atlas.ti© (version 6.2, Scientific Software Development GmbH, Eden Prairie, MN) using a Grounded Theory approach (Charmaz, 2006). Grounded Theory methods are designed to discover theory within textual data. Classic Grounded Theory involves beginning with open coding, a process of labeling each line while remaining open to discovery and unrestricted by pre-existing theories. Codes are subsequently grouped into

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categories and compared to each other in the process of constant comparative analysis, a hallmark of grounded theory. The coding process becomes more focused as explanations for differences are sought and categories related to other categories. Memos are used to document theory development. Data collection progresses using theoretical sampling, in which an emerging theory is further explored by deliberately seeking out new participants with characteristics that may expand or challenge the theory.

In this study, open coding was conducted on 5 medical provider transcripts and 10 transgender transcripts. This subset of transcripts was chosen to maximize variability in provider type and facility for medical providers, and to maximize variability in age, race, and gender for transgender participants. Line-by-line coding of these transcripts produced over 100 initial codes. These codes were examined for overlap, then collapsed into 30 broader codes that were used for focused coding of the remaining transcripts. These codes were then organized into 5 categories. Coded text was extracted, organized by category, and read in multiple iterations using constant comparisons between and within texts to identify key processes related to the manifestation and function of stigma in the medical encounter. All medical provider transcripts were analyzed in this manner. Transcripts for the transgender participants were analyzed in this manner until data saturation (i.e. no new themes) was reached at 30 interviews. The remaining transcripts were read for additional or disconfirming themes and codes were revised accordingly. Memos were used to organize and document the analytic process.

This method diverged from classic Grounded Theory in that new participants with specific theoretically relevant characteristics were not sought. Due to the sensitive nature of the topic and the importance of protecting the confidentiality of transgender participants, it was not feasible to select participants on the basis of emerging theory, and we were unable to re-contact participants for additional interviews to expand upon emerging themes. Instead, we specifically looked for confirming and disconfirming data within the remaining transcripts after data saturation was reached.

Credibility

Community consultations were held with transgender participants after the interviews were completed and preliminary data analysis had taken place. Ten transmen and seven transwomen participated in these meetings. During the meetings, preliminary findings from the study were presented in the form of vignettes and community members provided feedback and interpretation of results as well as recommendations for use of the findings. Input from these community consultations informed the results presented below. In addition, peer debriefing was conducted with six public health colleagues, including three medical providers, in order to seek alternative understandings of the data.

Findings

Categories of codes

The codes were organized into five categories: feelings about transgender identities, feelings about transgender hormone therapy, learning about transgender health, clinical interactions with transgender patients, and interactions with colleagues. The last category was used only for provider transcripts. Uncertainty emerged as a recurrent theme within each of these categories. Iterative analysis of the processes surrounding uncertainty and how it was managed in clinical interactions provided the framework for the theory described below.

Managing uncertainty and establishing authority – the theory

Establishing authority is the central social process identified during analysis of the qualitative data. In this process, stigma creates the conditions which challenge expected power relations (Fig. 1) between provider and patient as well as provides mechanisms to maintain and/or reinforce those power relationships. Structural and institutional stigma ensure that transgender experiences and bodies are virtually absent from medical training and leaves most providers without clear guidelines for the medical encounter. This uncertainty can lead to ambivalence about providing care. Because transgender people are aware that most providers are not trained to meet their needs, they also approach the encounter with uncertainty about the provider's competence. The uncertainty experienced by both providers and transgender people challenges the traditional clinical relationship in which the medical provider is expected to be a knowledgeable medical authority, make appropriate assessments, and provide effective care; while the patient is expected to acquiesce to the provider's greater health care knowledge. Interpersonal stigma can serve to reinforce the traditional provider–patient power relationship. Both medical providers and transgender patients may resist or participate in the enactment of stigma during the medical encounter.

Structural and institutional stigma: creating the conditions

Transgender participants' narratives offered vivid details about their experiences of stigma and discrimination. Experiences included being denied services at public establishments, being harassed and assaulted in public spaces, being passed over for employment or being fired when their gender identity was discovered or disclosed, and even being sexually harassed or assaulted when housed with members of their birth sex in institutions such as shelters, treatment centers, or jail. Some respondents internalized this stigma and wrestled with self-hatred or projected negative attitudes toward other transgender people. Most had learned to anticipate discrimination. This anticipation led some to describe limiting their geographic, employment, and health care options to avoid exposure to additional discrimination. Other transgender participants were grateful to be allowed to

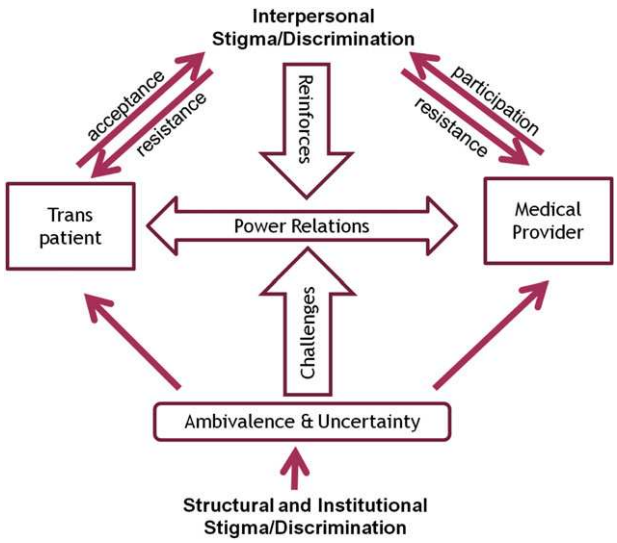

Fig. 1. Managing Uncertainty and Establishing Authority: A grounded theory of how stigma manifests as a force impacting power relations between medical providers and transgender patients.

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access basic needs, such as housing, without being evicted because of their gender identity.

Most medical providers were aware of the difficulties transgender people face, including much of the stigma and discrimination described by transgender people themselves. The providers felt that these difficulties led to a high prevalence of mental health and behavioral issues which made transgender people difficult to deal with as patients. One of the physicians put it this way,

> *They've been kicked around so much in their lives because of the territory they've had to traverse that there tend to be a lot of maladaptive behaviors that they've been habituated to. No blame there, but that can make the patients a lot harder to deal with and then they in turn have a hard time integrating into the community.* — Primary care physician

Uncertainty and ambivalence

Transgender participants were well aware that medical providers were not exempt from the negative attitudes held generally in society toward transgender people. They anticipated that providers would not only be unprepared to meet their medical needs, but may also be unprepared for their very existence. This situation created mutual discomfort best described by one of the transwomen participants, who stated, "Sometimes it might be a shocker [for a provider to see a transgender patient]. Yeah, but sometimes, you know, they might be scared, but at the same time, well, boy oh boy, if you think that you're uncomfortable and you're scared, we are, too. We are, too." Respondents expressed frustration about provider's uncertainty about which name or pronoun to use as well as their lack of knowledge of transgender medicine. One transman put it this way:

> *If you see two doctors, one will use male pronouns and the other will use female pronouns and you're kind of like, this is just awkward now, like, "should it be that hard?". . . Ideal healthcare would be transgender services being similar to diabetes services, similar to just other services where you can walk in and people don't look at you like, "What's that?"*

Transgender respondents used various strategies to prepare for or respond to this general gap in medical providers' knowledge. Some participants simply asked providers to refill previous prescriptions without expectations of medical monitoring or other standard care.

> *I don't know how knowledgeable she is. She's not an endocrinologist. She just knew that I was taking whatever medication from a previous physician, and she just duplicated that as well, so I don't think she goes, "Well, let's see. You might not need this much. You might– yeah, you need a little bit more." She just went, "Okay," so she just kept the same medication going.* — Transwoman

More assertive participants demanded better care from their inexperienced providers. This particular participant describes how he handled a difficult encounter with a medical provider who had never seen a transgender patient before him.

> *I actually spoke to her afterward. I'm like, "You know, it's 2009. In 2009, you're going to have more clients like me. What are you going to do for best practices? These are unacceptable standards of care." And she was explaining to me, "Well, this is the first time something like this has happened." I'm like, "Granted, but you need to prepare yourself for different types of people walking into your office."* — Transman

Some sought out recommendations from friends or searched the internet to find providers experienced with transgender patients. As one transman, stated, "*I was trying to figure out what was going on with me. I didn't want the additional burden of having to educate my provider on top of that. And the last thing I wanted was to be a training case for a practitioner who had never provided care to a transgendered person before*." However, some transgender participants who used this strategy were still frustrated by their provider's limited knowledge and found themselves trying to re-educate their medical providers:

> *I even went on the Internet myself and I printed out hormone regimens for oral and for injections and everything. . . I shouldn't have to go online and pull up a transgendered hormone regimen because I feel as though my doctor isn't prescribing the right hormone regimen for me. I shouldn't have to take that in there. You should already know. So I think that's one of the only things that kind of makes me angry.* — Transwoman

All but one of the medical providers expressed feeling either ambivalent about or unprepared for transgender patients. The endocrinologists who were interviewed felt medically prepared to manage hormones yet expressed ambivalence about the psychosocial issues raised by their transgender patients. Several providers (both primary care and endocrinologists) struggled with the concept of transgender altogether and expressed ambivalence about the necessity for gender confirming therapies, even though they prescribed them.

> *I find the whole area difficult. Nobody really understands it. I don't. I'm accepting of it because I see it, and I believe it, but obviously we don't understand it . . . So part of me wants to sort of say like, "Can't you just dress as a woman," or "Can't you just be a tomboy and not have to get involved with hormones and stuff?"* — Endocrinologist

Providers who felt uncertain about the appropriateness of transgender care described strategies to manage this ambivalence. Most providers sought a specific narrative of lifelong discomfort with natal sex as confirmation that patients met criteria for gender affirming therapies and many required a letter from a mental health provider confirming a diagnosis of Gender Identity Disorder. All of the primary care providers reported feeling unprepared for their first medical encounter with a transgender patient. They described several strategies for handling their lack of preparation, including seeking out information from experienced colleagues or through other sources such as books and online material; letting the patient guide the encounter and tell them what to do; learning by trial and error; or refusing to provide care.

> *When I started having some patients that were gonna come to me and I was gonna be their primary care provider, then it was like, "Oh goodness, I need to learn. I actually need to learn the fundamentals, the basics."* — Primary care provider

Only the adolescent specialist expressed confidence in her medical preparation to see the transgender young people in her practice and denied any ambivalence about providing gender confirming therapies. She felt that her competence was grounded in her medical training in adolescent hormonal development; and her comfort with transgender patients was related to her chosen commitment to run a medical practice that intentionally catered to socially marginalized HIV-infected youth.

Establishing authority: the function of stigma

Regardless of the neutrality of the verbalized strategy chosen by each medical provider to manage his or her medical uncertainty or ambivalence about providing transgender health care, their narratives also suggested ways in which medical providers consciously or subconsciously use stigma to manage uncertainty's threat to their medical authority. The narrative below demonstrates a provider's effort to re-establish authority in the medical visit with a transgender patient who challenged her knowledge:

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My worst was actually a patient who I felt like had read too much on the internet. Had all the terms of what to do and words I didn't even recognize and acronyms of things of feminization, surgery, and things I knew about but like these little words that I had never heard and just read so much on the internet that the whole visit was spent dispelling all those myths or all that time and I think it was the worst because even after the end of the visit you feel like that patient still doesn't trust what you're telling them. Following your recommendations but I think very cautious of what you're telling him because that patient thinks– the patient at the time just thought he knew everything she had read on the internet was correct. So I think that's what it was, leaving that visit like I don't know if this patient actually understands or trusts my judgment. – Primary care provider

The importance of maintaining the expected social role of the medical provider as a trusted medical authority is clear in this narrative. It is also apparent that the threat to this authority led the provider to dismiss the patient's knowledge as "myths" even though she admits to not knowing or understanding much of what the patient was telling her. The patient is blamed for the negative nature of this encounter because he "read too much on the internet." Table 1 includes example quotes from the many episodes in which both medical providers and transgender participants described blaming, shaming, othering and discrimination enacted by health care providers toward transgender patients. This process of blaming, shaming, othering, and discrimination demonstrates medical providers' power to negatively label transgender patients and act upon those negative associations. These actions reinforce the medical provider's authority by positioning the transgender patient as inherently problematic.

Table 1
Example quotes of interpersonal stigma and discrimination in health care encounters.

Blaming	*My biggest thing that comes up is like just dealing with my own prejudice against people that have an excessive preoccupation with physical appearance. That's where I get into trouble or into judging people. . . . You know so it's not I don't have a problem with a trans woman wanting to look like a woman. But some of my experience with patients is it's this obsession and it's- like it's never going to be okay. And I understand where that comes from but I think it's more of a psychological problem.* – Primary care provider
Shaming	*The nurse actually said to me, "So, that's a pretty– that's a boy's name. Do you think you're a little boy?"* – Transman
Othering	*These can be difficult patients, particularly trans women often have had pretty rough experiences and are pretty rough people and not necessarily compliant with visits or medications, follow up. And I swear there's a higher incidence of personality disorders among trans women so it can be a difficult group. I have no way of knowing. It could be anything from environmental stresses to something that's linked to whatever gene causes transgenderism.* – Primary care provider
Discriminating	*I almost apologize to them. I'm sorry that I bring this up so often assuming that they're having multiple partners. You know, like I don't mean to beat a dead horse but I'm like, are you really only having one partner? And what exactly are you doing? . . . .Is it my prejudice that maybe I'm testing my trans patients more often than I might be testing a gay patient or more often than I'm testing a heterosexual patient; that I'm assuming that their behavior is riskier and therefore that they need to be tested more often if they're saying that they're not having sex for money or that they are using condoms most of the time. So, I don't know. Am I doing– I don't want to over test but I don't want to under test and it's definitely something that I fight with myself about because I don't want to make somebody uncomfortable and be like oh, well you know, they like coming to see me except for the fact that every time they see me, I swab something and make them pee in a cup and give blood work because that's not fun either. I don't do that to every other patient.* – Primary care provider

However, this process of stigma and discrimination was a dynamic one in which providers sometimes struggled with their participation. This is evidenced by a quote in Table 1 from a primary care provider who questioned whether her differential treatment of transgender patients was appropriate. Other providers described movement from initial discomfort to coming to understand transgender patients as real people with real health care needs. And yet others described active efforts to resist transgender discrimination and protect transgender patients.

I spent the first 15 years of my career in the emergency room. So I had a lot of transgender patients that would come through there and I would personally try to take them as patients so that they wouldn't be discriminated or laughed or ridiculed. – Primary care provider

Where providers sat on the continuum between participation and resistance to transgender stigma/discrimination seemed to be a function of empathy. Lesbian and gay providers as well as other providers who felt a personal connection to transgender people were more likely to express resistance to stigmatization of transgender people.

I'm sure that being a gay man had helped me have an early open mindedness about difference and societal misunderstanding or non-understanding of something other than what is defined as sort of normal and mainstream. So it may have been easier for me in that regard to a degree. – Primary care provider

Resistance to stigma was not limited to more positive attitudes toward transgender patients but went hand in hand with a willingness to relinquish some power in the medical encounter and let the patient lead. As one provider stated, "*You may do some things that are unnecessary just because of the patient's outlook and their self-comfort and or let them try something and see if it seems to make any difference. There's a little bit of giving in I think sometimes*." Another provider went as far as to say, "*My agenda has to change according to what the patient really needs that day*."

Transgender participants also demonstrated a dynamic interplay between acceptance and resistance to stigma. Some actively resisted stigmatization and sought to claim power in their relationship with providers while a few fully acquiesced to the medical authority of the provider. One dramatic example was a transwoman who told a story of being advised by her surgeon about what breast size would be appropriate for her, agreeing to this size, then waking up to find that she had breast implants 50% larger than they had agreed upon. When asked if the surgeon had made this decision on his own, she replied, "*He made it on his own and I'm glad he did. It was great. It was great. I'm glad that he decided to run with his gut, you know*?"

Whether a transgender person chose to resist stigma and discrimination by health care providers depended on whether he or she felt that she had other options. For example, one transman described himself as someone who felt very empowered and who had confronted several health care providers about their stigmatizing attitudes or behaviors; however, he also told two stories of tolerating discrimination in order to get medical care that he needed. The dilemma for transgender patients is best illustrated by a transwoman who begins the narrative below claiming the power to guide her own medical care and ends with feeling trapped in care with a provider who does not meet her needs:

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You just have to really, really stay on them and let them know, "This is what I need. This is what I want," and talk to them. "I went online and I saw this. I think this would be good for me." You have to really . . . I have to do the research. I have to learn as much about me and what I need than to just take what somebody gives me. So that's a little– that makes me a little bit angry too, because I did walk away from there a couple of times– always ended up going back because there's nowhere else to go– so I always wind up going back. But I think they need to learn how to cater to us a little bit more– understand every individual person's needs.

Discussion

Functional theory asserts that we hold certain attitudes because they serve a specific psychological functions (Perloff, 2003). Attitudes have been found to: (1) provide a way to make sense of the world (knowledge), (2) allow us to be accepted by others (social-adjustive), (3) let us express a core value (value-adjustive), and (4) serve as a defense against uncomfortable truths (ego-defensive). Stigmatizing attitudes toward transgender people could serve any or all of those functions. Because transgender individuals challenge societal norms for gender expression, negative attitudes toward them can serve as a psychological defense against discomfort with gender non-conformity and allow the expression of the core belief in gender conformity. Because a static gender binary is so reified in U.S. society, negative attitudes toward gender variance can also serve to make sense of the world and allow the attitude holder to be accepted by most groups in society.

However, functional theory is limited in that it does not acknowledge the role of power. All social relationships take place within a social structure where some groups have more social, political, and economic power than others. Functional theory does not consider how social inequalities affect the function of stigma. The social roles of provider and patient are one example of a social hierarchy. Therefore, the provider–patient relationship provides a useful social site to examine how interpersonal stigma functions within unequal relationships.

Some stigma researchers argue that stigma is inextricably tied to the reproduction of social difference and reinforces existing inequalities (Parker & Aggleton, 2003). The findings of this study provide support for this assertion. Interpersonal stigma and discrimination during transgender health care encounters served to reinforce the authority of the medical provider in the face of his or her uncertainty and ambivalence about transgender people and their care as well as the transgender patient's uncertainty about the provider's competence.

Findings from this study are also consistent with the attribution model of stigma (Weiner, Perry, & Magnusson, 1988). The attribution model posits that people are more to likely to respond negatively to those whom they believe to be responsible for their stigmatized identities than those whose stigmatized identities are believed to be beyond their control. In this study, providers who expressed uncertainty about the nature of transgender identity were more likely to express stigmatizing attitudes toward transgender patients than those who felt that transgender people were innately compelled to express their gender identity.

Others have challenged the validity of the attribution model and proposed alternative theories. Hegarty and colleagues note that findings from cross-sectional studies testing the attribution model could also be explained by the justification-suppression model, which asserts that attributions to controllable causes are justifications for pre-existing prejudices (Hegarty & Golden, 2008). Phelan has argued that while that attribution theory would predict that a belief in the genetic nature of an attribute would result in less stigma, evidence suggests that such "genetic essentialism" can exacerbate stigma (Phelan, 2005).

Understanding the role of power may help to explain these seemingly disparate models. People who enact stigma must have access to social, economic, or political power that enables them to translate their negative attitudes into discriminatory behavior. The very reason that stigma serves to reinforce existing structural inequalities is because enacting it depends upon possession of power. If the function of stigma is to reinforce existing social hierarchies, then challenges to current power structures may be the social impetus for stigma. Those who challenge this structure would be stigmatized whether it is by assuming they are inherently inferior and justifying it or by attributing their inferiority to choices they have made.

The current study contributes to the understanding of stigma by describing the process and function of stigma in reinforcing medical authority during patient encounters. These findings expand upon functional theory by acknowledging the role of relative social power in the enactment of interpersonal stigma. As one seeks to reduce stigma that impacts the health of marginalized populations, it is critical that we have research that elucidates the causes and functions of stigma and discrimination. Better understanding how stigma operates against transgender people in health care settings can provide insights into how it may operate with other marginalized groups who experience health inequalities.

All of the respondents were drawn from one urban area with a particular sociopolitical context and specific set of resources for transgender people. Therefore the process of stigma manifestation in health care encounters found in this study may not transfer to other settings. Transgender respondents were recruited via social networks, therefore more isolated transgender people were less likely to participate. Respondents' experience of health care may be quite different from those of transgender people who are not as socially connected. Finally, the medical providers who participated in this study were a select group who had experience providing health care to transgender people and were willing to talk about it face-to-face with another provider. These providers may have less stigmatizing encounters with transgender patients than other providers and may have de-emphasized any negative attitudes they hold toward transgender patients knowing the topic of the research study and being colleagues with the principle investigator. This context makes it possible that the role of stigma in the health care encounter with transgender people has been underappreciated in this study. However, it is also possible that these providers were more forthright with a colleague whom they may have perceived as someone who would understand their perspective as someone who also provides medical care to transgender individuals.

Future research on stigma and discrimination is needed to expand upon and test this theory in other settings. Vignettes may be a useful tool for exploring stigma among medical providers who do not have experience caring for transgender patients. It will also be important to assess the content and function of stigmatizing attitudes among health care workers at different levels of the medical hierarchy, including nursing, administration, and leadership. Testing these hypothesized mechanisms of stigma and discrimination among a large number of health care providers would be an important step to inform stigma reduction interventions for marginalized groups who experience health disparities.

Acknowledgments

The authors would like to acknowledge the invaluable contributions of the transgender community advisory boards for their participation in all stages of the research. In addition, we would like

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to express our gratitude for the courageous study participants who agreed to share their stories with us. Without them, none of this research would have been possible.

References

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. London: Sage Publications Ltd.

Corrigan, P. W., Markowitz, F. E., & Watson, A. C. (2004). Structural levels of mental illness stigma and discrimination. *Schizophrenia Bulletin, 30*, 481–491.

Deacon, H. (2006). Towards a sustainable theory of health-related stigma: lessons from the HIV/AIDS literature. *Journal of Community & Applied Social Psychology, 16*, 418–425.

Dean, L., Meyer, I., Robinson, K., Sell, R., Sember, R., Silenzio, V. B., et al. (2000). Lesbian, gay, bisexual, and transgender health: findings and concerns. *Journal of the Gay and Lesbian Medical Association, 4*, 102–151.

De Santis, J. P. (2009). HIV infection risk factors among male-to-female transgender persons: a review of the literature. *Journal of the Association of Nurses in AIDS Care, 20*, 362–372.

Dorsen, C. (2012). An integrative review of nurse attitudes towards lesbian, gay, bisexual, and transgender patients. *Canadian Journal of Nursing Research, 44*, 18–43.

Dworkin, S. H., & Yi, H. (2003). LGBT identity, violence, and social justice: the psychological is political. *International Journal for the Advancement of Counselling, 25*, 269–279.

Eliason, M. J., Dibble, S. L., & Robertson, P. A. (2011). Lesbian, gay, bisexual, and transgender (LGBT) physicians' experiences in the workplace. *Journal of Homosexuality, 58*, 1355–1371.

Grant, J. M., Mottet, L. A., Tanis, J., Harrison, J., Herman, J. L., & Keisling, M. (2011). *Injustice at every turn: A report of the national transgender discrimination Survey*. Washington: National Center for Transgender Equality and National Gay and Lesbian Task Force.

Hegarty, P., & Golden, A. M. (2008). Attributional beliefs about the controllability of stigmatized traits: antecedents or justifications of prejudice? *Journal of Applied Social Psychology, 38*, 1023–1044.

Kenagy, G. P. (2005). Transgender health: findings from two needs assessment studies in Philadelphia. *Health & Social Work, 30*, 19–26.

Krieger, N. (1999). Embodying inequality: a review of concepts, measures, and methods for studying health consequences of discrimination. *International Journal of Health Services, 29*, 295–352.

Krieger, N. (2012). Methods for the scientific study of discrimination and health: an ecosocial approach. *American Journal of Public Health*, e1–e10.

Lambda Legal. (2010). *When health care isn't Caring: Lambda Legal's Survey of discrimination against LGBT people and people with HIV*. New York: Lambda Legal.

Lawrence, A. A., Meyer, I. H., & Northridge, M. E. (2007). *Transgender health concerns*In *The health of sexual minorities: Public health perspectives on lesbian, gay, bisexual, and transgender populations*. New York, NY, US: Springer Science + -Business Media, pp. 473–505.

Link, B. G., & Phelan, J. (1995). Social conditions as fundamental causes of disease. *Journal of Health & Social Behavior*80–94, Spec No.

Link, B. G., & Phelan, J. C. (2006). Stigma and its public health implications. *Lancet, 367*, 528–529.

Lombardi, E. L., Wilchins, R. A., Priesing, D., & Malouf, D. (2001). Gender violence: transgender experiences with violence and discrimination. *Journal of Homosexuality, 42*, 89–101.

Lurie, S. (2005). Identifying training needs of health-care providers related to treatment and care of transgendered patients: a qualitative needs assessment conducted in New England. *International Journal of Transgenderism, 8*, 93–112.

Meyer, I. H., & Northridge, M. E. (2007). *Prejudice and discrimination as social stressors*In *The health of sexual minorities: Public health perspectives on lesbian, gay, bisexual, and transgender populations*. New York, NY, US: Springer Science + Business Media, pp. 242–267.

National Center for Health Statistics. (2007).

Norton, A. T., & Herek, G. M. (2012). Heterosexuals' attitudes toward transgender people: findings from a national probability sample of US adults. *Sex Roles*, 1–16.

Obedin-Maliver, J., Goldsmith, E. S., Stewart, L., White, W., Tran, E., Brenman, S., et al. (2011). Lesbian, gay, bisexual, and transgender-related content in undergraduate medical education. *Journal of the American Medical Association, 306*, 971–977.

Parker, R., & Aggleton, P. (2003). HIV and AIDS-related stigma and discrimination: a conceptual framework and implications for action. *Social Science & Medicine, 57*, 13–24.

Perloff, R. (2003). *The dynamics of persuasion: Communication and attitudes in the 21st century* (3rd ed.). Mahwah, NJ: Lawrence Erlbaum.

Phelan, J. C. (2005). Geneticization of deviant behavior and consequences for stigma: the case of mental illness. *Journal of Health and Social Behavior, 46*, 307–322.

Risser, J. M. H., Shelton, A., McCurdy, S., Atkinson, J., Padgett, P., Useche, B., et al. (2005). Sex, drugs, violence, and HIV status among male-to-female transgender persons in Houston, Texas. *International Journal of Transgenderism, 8*, 67–74.

Sanchez, N. F., Sanchez, J. P., & Danoff, A. (2009). Health care utilization, barriers to care, and hormone usage among male-to-female transgender persons in New York City. *American Journal of Public Health, 99*, 713–719.

Vanderleest, J. G., & Galper, C. Q. (2009). Improving the health of transgender people: transgender medical education in Arizona. *Journal of the Association of Nurses in AIDS Care, 20*, 411–416.

Weiner, B., Perry, R. P., & Magnusson, J. (1988). An attributional analysis of reactions to stigmas. *Journal of Personality and Social Psychology, 55*, 738–748.

Xavier, J. M., Hannold, J. A., Bradford, J., & Simmons, R. (2007). *The health, health-related needs, and lifecourse experiences of transgender Virginians*.